

**FORM A**  
**CERTIFICATE OF POSTGRADUATE TRAINING**

**INSTRUCTIONS:** To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada. Either the hospital seal OR notary seal must be on this form. Errors shall be noted by one line through the error and initials of correcting party. No whiteouts or strikeouts are acceptable on this form and may result in a delay of the application process. This form may be sent with the applicant's application packet only if the original envelope is unopened, and the program director has signed his/her name across the back of the envelope. Altered envelopes which contain official, original, or certified official documents will not be accepted.

**PART 1: TO BE COMPLETED BY THE APPLICANT.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

**PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR.**

**Attention Program Director:** Do not sign and date this form before the last day of any postgraduate training year that will be used by the applicant to qualify for licensure. Requirements for licensure in Georgia:

**US Medical School Graduates: One Year**

**Int'l Medical School Graduates: Before July 1, 1985: One Year  
After July 1, 1985: Three Years**

Please print, type or stamp the following information:

Name of Program: \_\_\_\_\_

Sponsored by: \_\_\_\_\_

Program ID: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Affiliated University: \_\_\_\_\_

Composite State Board of Medical  
Examiners Use Only

AMA/AOA Year \_\_\_\_\_

AMA/AOA Page \_\_\_\_\_

RCPSC Year \_\_\_\_\_

RCPSC Page \_\_\_\_\_

CFPC Internet \_\_\_\_\_

This is to certify that the applicant name in Part 1 of this form has successfully completed (please check one)

\_\_\_\_ Internship      \_\_\_\_ Residency      \_\_\_\_ Chief Residency      \_\_\_\_ Fellowship      \_\_\_\_ Research

from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_ in the specialty/subspecialty of \_\_\_\_\_.

It is further certified that this program is accredited by the Accreditation Council for Graduate Medical Education (ACGME) or by the Council on Postdoctoral Training (ECCOPT) for the training of medical and osteopathic interns, residents, fellowships, and research as an Accredited Program, Graduate Medical Education Teaching Institution, or Osteopathic Postdoctoral Training Program.

Any leave of absences requested/reported?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any probationary action ever taken?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any disciplinary actions or investigations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any special requirements or limitations due to questions of academic incompetence, disciplinary problem, etc?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If "YES" to any of the above questions, please provide a written explanation.

**Completion of this form will certify that the individual named in Part 1 above completed a period of accredited postgraduate training at this facility. This form shall be signed by the Program Director (MD or DO only).**

\_\_\_\_\_  
Program Director's Name

\_\_\_\_\_  
Notary's Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Notary Signature

Affix the institutional seal in this space. If you have no seal available, you are required to have this form notarized.